STATE OF CALIFORNIA
DEPARTMENT OF MOTOR VEHICLES
A Public Service Agency

DRIVER MEDICAL EVALUATION

(Medical information is CONFIDENTIAL under Section 1808.5 CVC)

PHYSICIAN *RETURN FORM TO:*

BY THE INDICATED DATE:

INSTRUCTIONS TO THE DRIVER: Please take this form to the doctor most familiar with your health history and current medical condition. Be sure to complete and sign the health history section below **before** giving this form to your doctor.

NAME *(LAST, FIRST, MIDDLE)*	DRIVER LICENSE NO.	BIRTH DATE	FIELD FILE

STREET ADDRESS	CITY	ZIP	PATIENT'S DAYTIME OR HOME PHONE NO.
			( )

PATIENT MUST COMPLETE HEALTH HISTORY BELOW. *(Please explain any "YES" answers)*

YES	NO	
		Head, neck, or spinal injury
		Seizure, convulsions, or fainting
		Dizziness or frequent headaches
		Eye problem (except corrective lenses)
		Cardiovascular (heart or blood vessel) disease
		Stroke
		Lung disease (include TB and asthma)
		Nervous stomach or ulcer
		Diabetes
		Kidney disease (including stones or blood in urine)
		Muscular disease
		Extensive confinement by illness or injury
		Permanent defect
		Psychiatric disorder
		Any other nervous disorder
		Problems with the use of alcohol or drugs
		Rheumatic fever
		Suffering from any other disease
		Any major illness last 5 years
		Any operations last 5 years
		Currently taking medications

EXPLANATION: *(Include onset date, diagnosis, medication, doctor's name and address and any current condition or limitation. Attach additional sheet, if needed).*

I certify under the penalty of perjury, under the laws of the State of California, that I have provided true and complete information concerning my health.

DATE	DRIVER'S SIGNATURE
	X

INSTRUCTIONS TO THE DOCTOR: The Department of Motor Vehicles' records indicate your patient may have a condition that could affect the safe operation of a motor vehicle. In this case, the Department is concerned about the following condition(s): _____.
(To be completed by DMV hearing officer)

With your assistance, we hope to resolve the matter with a minimum of inconvenience to all concerned.

The Health History section should be completed and signed by the patient before you complete this evaluation.

Your experience and knowledge of the patient's condition, results of medical examinations, and treatment plans, will be of great value in assisting the department to determine a proper licensing decision. PLEASE ANSWER ALL QUESTIONS on this form that are applicable to your patient's condition(s). You may furnish a narrative report if you prefer, but please include all information pertinent to your patient. *The department has sole responsibility for any decision regarding the patient's driving qualifications and licensure. The department will also consider non-medical factors in reaching a decision.*

TREATMENT BY OTHER DOCTOR(S)

IS THIS PATIENT BEING TREATED FOR ANY CONDITION BY ANOTHER DOCTOR?

☐ **Yes** ☐ **No**

IF YES, PLEASE INDICATE NAME OF TREATING DOCTOR(S)

CONDITION BEING TREATED

TREATMENT UNDER YOUR SUPERVISION

DIAGNOSIS *(IF THE DIAGNOSIS IS A DISORDER CHARACTERIZED BY LAPSES OF CONSCIOUSNESS, DEMENTIA, OR DIABETES, COMPLETE PAGE 3 OR 4.)*

DO YOU NEED TO SEE YOUR PATIENT AT REGULAR INTERVALS? IF YES, HOW OFTEN?

☐ Yes ☐ No

PROGNOSIS

IS THE CONDITION

☐ Improving ☐ Stable ☐ Worsening or deteriorating ☐ Subject to change *(IF MULTIPLE CONDITIONS, PLEASE DESCRIBE STATUS AND PROGNOSIS IN COMMENTS BELOW.)*

MANIFESTATIONS: (SYMPTOMS)

(PRESENT)

(PAST)

MAY CONDITION IMPAIR VISION?

☐ **Yes** ☐ **No**

HOW LONG HAS THIS PERSON BEEN YOUR PATIENT?

DATE OF LAST EXAMINATION

IS YOUR PATIENT UNDER A CONTROLLED MEDICAL PROGRAM?

☐ **Yes** ☐ **No**

HOW LONG HAS CONTROL BEEN MAINTAINED?

IS THE PATIENT ADHERING TO THE MEDICAL REGIMEN? IF NO, PLEASE EXPLAIN:

☐ **Yes** ☐ **No**

IS THE PATIENT KNOWLEDGEABLE ABOUT THE MEDICAL CONDITION?

☐ **Yes** ☐ **No**

LIST THE MEDICATIONS PRESCRIBED. PLEASE INCLUDE DOSAGE AND FREQUENCY OF USE

WHEN WAS THE LAST MEDICATION CHANGE MADE?

WOULD THE SIDE EFFECTS FROM THE PRESCRIBED MEDICATIONS INTERFERE WITH THE SAFE OPERATION OF A MOTOR VEHICLE?

☐ **Yes** ☐ **No** If yes, please describe:

IN YOUR OPINION, DOES YOUR PATIENT'S MEDICAL CONDITION AFFECT SAFE DRIVING?

☐ Yes ☐ No ☐ Uncertain

HAVE YOU ADVISED AGAINST DRIVING?

☐ Yes ☐ No

DOCTOR'S COMMENTS:

LEVELS OF FUNCTIONAL IMPAIRMENTS

Functional impairments that may affect safe driving ability. Please check where applicable.

	MILD	MODERATE	SEVERE
Visual neglect	☐	☐	☐
☐ Left side ☐ Right side			
Loss of upper extremity motor control	☐	☐	☐
☐ Left side ☐ Right side			
Loss of lower extremity motor control	☐	☐	☐
☐ Left side ☐ Right side			

WOULD ADAPTIVE DEVICES AID YOUR PATIENT IN COMPENSATING FOR HIS/HER DISABILITY?

☐ Yes ☐ No ☐ Uncertain

IF YES, PLEASE DESCRIBE

WOULD YOU RECOMMEND A DRIVING TEST BE GIVEN BY DMV?

☐ Yes ☐ No ☐ Uncertain

LAPSE OF CONSCIOUSNESS DISORDER

PLEASE IDENTIFY THE LAPSE OF CONSCIOUSNESS DISORDER BEING REPORTED *(Type of seizure, nocturnal, isolated, syncope, blackouts, etc.)*	DATE(S) OF EPISODE(S) IN THE PAST THREE YEARS
DATE OF ONSET, IF KNOWN	***DATE AND TIME OF LAST EPISODE***

Please indicate the impairments identified below that are presently shown by your patient.

	YES	NO	UNCERTAIN
Sporadic loss of conscious awareness	☐	☐	☐
Loss of consciousness	☐	☐	☐
Impaired motor function	☐	☐	☐

EFFECTS AFTER EPISODE

Confusion	☐	☐	☐
Diminished concentration	☐	☐	☐
Diminished judgment	☐	☐	☐
Memory loss	☐	☐	☐
If medication is taken to control seizures, are the serum levels recorded?	☐	☐	
Are the serum levels medically acceptable?	☐	☐	

DEMENTIA OR COGNITIVE IMPAIRMENTS

☐ **Alzheimer's Disease**
☐ **Other Dementia** *(Please describe the type of dementia below, e.g., multi-infarct, metabolic, post-traumatic.)*

HISTORY OF DISEASE, RESULTS OF TESTING, ETC.

Using the definitions given below, please rate the severity of the following forms of cognitive impairments in this patient.

†**DEFINITIONS:** *(Based on DSM III-R)*

Mild: Judgment is relatively intact but work or social activities are significantly impaired. Ability to safely operate a motor vehicle may or may not be impaired.

Moderate: Independent living is hazardous and some degree of supervision is necessary. The individual is unable to cope with the environment and driving would be dangerous.

Severe: Activities of daily living are so impaired that continual supervision is required. This person is incapable of driving a motor vehicle.

	NONE	MILD†	MODERATE†	SEVERE†	UNCERTAIN
Memory Loss	☐	☐	☐	☐	☐
Depression, secondary to dementia	☐	☐	☐	☐	☐
Diminished Judgment	☐	☐	☐	☐	☐
Impaired Attention	☐	☐	☐	☐	☐
Impaired Language Skills	☐	☐	☐	☐	☐
Impaired Visual Spatial Skills	☐	☐	☐	☐	☐
Impulsive Behavior	☐	☐	☐	☐	☐
Problem Solving Deficits	☐	☐	☐	☐	☐
Loss of Awareness of Disability	☐	☐	☐	☐	☐
OVERALL DEGREE OF IMPAIRMENT		☐	☐	☐	

DIABETES

PLEASE INDICATE THE TYPE OF DIABETES THIS PATIENT HAS
☐ Type I ☐ Type 2 ☐ Gestational

DATE OF DIAGNOSIS

WHAT METHOD OF TREATMENT IS REQUIRED?
☐ Controlled diet ☐ Oral diabetes medication ☐ Insulin injections ☐ Insulin pump ☐ Other:

HAS THIS PATIENT RECEIVED DIABETES EDUCATION FROM A HEALTH CARE TEAM?
☐ Yes ☐ No

DOES THIS PATIENT COMPLY WITH THE PRESCRIBED TREATMENT PLAN?
☐ Yes ☐ No

IF NO, PLEASE EXPLAIN

IS THE DIABETES CONTROLLED AT THIS TIME?
☐ Yes ☐ No

IF YES, HOW LONG HAS CONTROL BEEN MAINTAINED?

IF NO, PLEASE EXPLAIN

WHAT ARE THIS PATIENT'S FASTING BLOOD GLUCOSE LEVELS?

AFTER HOW MANY HOURS OF FASTING?

WITHIN THE LAST THREE YEARS, HAS THIS PATIENT EXPERIENCED
☐ Hypoglycemic episodes? ☐ Hyperglycemic episodes?

REASON FOR EPISODES (e.g., non-compliance w/regimen, change in condition, insulin unavailable, illness, etc.)

Please indicate the complications manifested by the hypoglycemic or hyperglycemic episodes and rate the severity of each.

	NONE	MILD	MODERATE	SEVERE	UNCERTAIN
Abdominal pain	☐	☐	☐	☐	☐
Cognitive deficits	☐	☐	☐	☐	☐
Confusion	☐	☐	☐	☐	☐
Confusion or disorientation	☐	☐	☐	☐	☐
Incoordination	☐	☐	☐	☐	☐
Hypoglycemic unawareness	☐	☐	☐	☐	☐
Lack of stamina	☐	☐	☐	☐	☐
Loss of consciousness	☐	☐	☐	☐	☐
Stupor	☐	☐	☐	☐	☐
Visual changes	☐	☐	☐	☐	☐
Ketoacidosis	☐	☐	☐	☐	☐
Slowed reactions	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐
Weakness or fatigue	☐	☐	☐	☐	☐
Other					

DOES THIS PATIENT MANAGE HYPOGLYCEMIC OR HYPERGLYCEMIC EPISODES WITH OR WITHOUT HELP?
☐ With ☐ Without

HAS THIS PATIENT'S DIABETES CAUSED ANY OF THE FOLLOWING CHRONIC COMPLICATIONS?
☐ Visual changes ☐ Kidney disease ☐ Nervous system disease ☐ Vascular disease

PLEASE DESCRIBE THE EXTENT OF THE COMPLICATIONS

HAS THE PATIENT BEEN HOSPITALIZED WITHIN THE LAST THREE YEARS DUE TO DIABETES COMPLICATIONS?
☐ Yes ☐ No If yes, please give dates:

WHAT COMPLICATIONS NECESSITATED HOSPITALIZATION?

HAS AMPUTATION BEEN NECESSARY?
☐ Yes ☐ No

IF YES, PLEASE EXPLAIN

ADDITIONAL COMMENTS BY DOCTOR

DRIVER'S ADVISORY STATEMENT

Medical information is required under the authority of Divisions 6 and 7 of the California Vehicle Code. Failure to provide the information is cause for refusal to issue a license or to withdraw the driving privilege.

All records of the Department of Motor Vehicles, relating to the physical or mental condition of any person, are confidential and not open to public inspection (California Vehicle Code Section 1808.5). Information used in determining driving qualifications is available to you and/or your representative with your signed authorization.

The department has sole responsibility for any decision regarding your driving qualifications and licensure. The department will also consider non-medical factors in reaching a decision.

MEDICAL INFORMATION AUTHORIZATION
(Valid for three years)

DOCTOR, HOSPITAL, OR MEDICAL FACILITY *(NAME AND ADDRESS)*

DATE	MEDICAL RECORD/PATIENT FILE NUMBER

I hereby authorize my doctor or hospital to answer any questions from the Department of Motor Vehicles, or its employees, relating to my physical or mental condition, and/or drug and/or alcohol use or abuse, and to release any related information or records to the Department of Motor Vehicles or its employees. Any expense involved is to be charged to me and not to the Department of Motor Vehicles.

I hereby authorize the Department of Motor Vehicles to receive any information relating to my physical or mental condition, and/or drug and/or alcohol use or abuse, and to use the same in determining whether I have the ability to operate a motor vehicle safely.

NOTE: You may wish to make a copy of the completed Driver Medical Evaluation for your records.

SIGNED	DATE
X	
WITNESS	DATE

DOCTOR'S SIGNATURE

DOCTOR'S SIGNATURE	DOCTOR'S NAME *(PRINTED)*	DATE
X		
CLASSIFICATION OR SPECIALTY	MEDICAL LICENSE NUMBER	TELEPHONE NUMBER
		( )